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OKLAHOMA HEALTH CARE AUTHORITY

June 30,1999

Ms. Sally Richardson
Center for Medicaid and State Operations
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Richardson:

The State of Oklahoma is pleased to submit this reques for a three-year extension of the ***SoonerCure*** Section § 1115(a) Research and Demonstration Waiver (Project No. 11-W-00048/6), pursuant to Section 4757 of the 1997 Balanced Budget Act.

The request has been developed in conformance with the Health Care Financing Administration's instructions. If granted, the extension period will run from January 1, 2001 through December 31,2003.

We look forward to your response. If you have any questions or need additional information, please contact Matt Lucas at (405) 530-3273.

Sincerely,

/s/

Michael Fogarty
Interim Chief Executive Officer
State of Oklahoma Medicaid Director

Cc: At Pagan, HCFA Dallas Regional Office
Tammy Auseon, HCFA Dallas Regional Office
Joyce Jordan, HCFA Baltimore Central Office

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

SOONERCARE DEMONSTRATION
WAIVER EXTENSION REQUEST
PROJECT NUMBER: 11-W-00048/6

Submitted: June 30,1999

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A. SUPPORTING DOCUMENTATION PROVIDED BY THE STATE

1. Yrograin Objectives

The ***SoonerCare*** waiver was submitted to the Health Care Financing Administration (HCFA) in early 1995 and became operational in 1996. In the period directly preceding development of ***Soonercare,*** the State of Oklahoma's Medicaid program was experiencing significant financial and service accessibility problems. Budgetary shortfalls had forced the State to reduce hospital, physician, and prescription drug coverage for adults. At the same time, access to primary and specialty care in rural areas, where providers are relatively sparse, was deteriorating in the face of declining physician participation.

The ***SoonerCare*** waiver program was developed to address, in a fiscally responsible manner, the growing imbalance between need and availability of services. More specifically, the waiver proposal identified eight program objectives to be accomplished through reform of the State's fee-for-service Medicaid program. These were:

- To improve access to preventive services, primary care, and early prenatal care for Oklahoma's Title XIX population.

- To ensure that every Title XIX beneficiary is able to choose a primary care provider who will serve as his or her family physician and be responsible for providing all basic medical services.

- Wherever practical, to enroll Title XIX beneficiaries into fully-integrated networks (federally qualified Managed Care Organizations (MCO) and State-certified health plans), and to give these networks responsibility for delivering the full scope of Medicaid-covered services in return for a monthly capitation.

- To build managed care capacity in Oklahoma's rural communities, and to test various alternatives for creating this capacity in order to identify the most effective model(s).

- To more closely align rural providers with their urban counterparts, so that rural Title XIX beneficiaries are better able to obtain access to needed specialty/referral services.

- To enhance the ability of rural communities to retain existing providers and attract new ones.

- To better integrate Title XIX beneficiaries, including long-term care recipients, with the privately insured population, through enrollment into managed care delivery systems serving both populations.

- To instill a greater degree of budget predictability into Oklahoma's Title XIX program, by moving from a fee-for-service program to one based on the concept of pre-payment.

As suggested by a number of the above objectives, Oklahoma's waiver proposal was unique in differentiating between urban and rural communities, the latter of which comprise most of the State. Because managed care was virtually non-existent in rural Oklahoma in 1995 (when the proposal was submitted), it was necessary for the State to design a non-traditional model that could serve to transition providers from fee-for-service to a prepaid system in a gradual manner. This alternative model has been one of the program's greatest successes, as discussed in detail below.

Objectives one through eight, and the State's progress in meeting them, is addressed below:

1.1 *To improve access to preventive services, primary care, and early prenatal care for Oklahoma's Title XIX population.*

Under the fee-for-service program that existed prior to ***SoonerCare,*** the State had no ability to offer beneficiaries a "medical home" in which to receive preventive and primary care services (including early prenatal care). Similarly, the State had no mechanism for holding providers accountable for their level of care coordination and case management.

Under ***SoonerCare,*** beneficiaries in the greater metropolitan areas of Oklahoma City, Tulsa, and Lawton have been enrolled into fully-capitated MCOs ***("SoonerCare Plus"*** model). These MCOs are responsible for linking each enrollee to a primary care provider who serves as his or her medical home. The MCOs, directly and through their provider networks, are required to conduct aggressive outreach to encourage members to obtain preventive and primary care services, particularly EPSDT services in the case of children.

In rural communities, beneficiaries have been enrolled with Primary Care Provider/Case Managers (PCP/CMs) who receive a capitation in return for furnishing a partially capitated benefit package, which includes primary and preventive services, and making referrals to specialists as appropriate ***("SoonerCare Choice"*** model). (Specialty, inpatient, and ancillary services continue to be paid fee-for-service in rural areas.)

Both the urban MCOs and rural PCP/CMs have made significant strides in furnishing preventive and primary care to ***SoonerCare*** enrollees. Detailed information about program accomplishments in this area is provided in section five, *Quality.*

1.2 *To ensure that every Title XIX beneficiary is able to choose a primary care provider who will serve as his or her family physician and be responsible for providing all basic medical services.*

As discussed above, all ***SoonerCare*** beneficiaries are linked to a primary care provider (PCPs in urban areas and PCP/CMs in rural areas) with responsibility for delivering basic health care and coordinating medically necessary referrals. The MCOs have constructed substantial primary care networks in the three metropolitan service areas, resulting in very low member-to-physician ratios. Currently, the MCOs' primary care

network consists of 659 providers serving 94,184 ***SoonerCare Plus*** enrollees resulting in a 143-to-1 ratio.[1] With a provider-patient ratio similar to the ***SoonerCare Plus*** program the number of participating ***SoonerCare Choice*** providers has increased steadily since the start of the program, resulting in continually improved access for rural beneficiaries.

1.3 *Wherever practical, to enroll Title XIX beneficiaries into fully-integrated networks (federally-qualified MCOs and State-certified health plans), and to give these networks responsibility for delivering the* **full** *scope of Medicaid-covered services in return for a monthly capitation.*

Under the ***SoonerCare Plus*** model, the State contracts with MCOs in the greater metropolitan areas of Oklahoma City, Tulsa, and Lawton. The MCOs are responsible for furnishing a full range of medical benefits—both physical and behavioral health—and for performing care coordination and case management as medically necessary.

Despite the relatively small number of licensed MCOs in Oklahoma (twelve in total, two of which are licensed but have no enrollees) the State has contracted with multiple health plans in each service area, giving beneficiaries the opportunity to choose from competing contractors. The State contracts today with four commercial MCOs, two of which enroll only Medicaid beneficiaries. All four have been participants' since the inception of the demonstration, a reflection of the State's success in developing successful long-term public-private partnerships.

In the first year of ***SoonerCare,*** MCO regions were tightly drawn around the three metropolitan areas. In year two, the State expanded the service areas to encompass surrounding rural counties. In square miles, each of the service areas more than doubled in size. Total MCO enrollment grew by about 20 percent, an indication of the truly rural nature of the expansion counties.

The year two expansions represented the State's first step toward implementing the "Rural Partnership" component of the demonstration. In the original waiver proposal, Oklahoma identified a series of actions that would gradually be undertaken to merge urban providers/networks with their rural counterparts. Other Rural Partnership activities are described in objective 5.

Since year two, Oklahoma has explored further expansion of the MCO service areas, as well as the establishment of a new service area in the southcentral portion of the State (Tulsa is in the northeast, Oklahoma City in the central, and Lawton in the southwest). However, because of the lack of comprehensive managed care networks in these more rural areas, the MCO regions have been left unchanged at this time. Instead, the State is focusing on further developing the ***SoonerCare Choice*** model (see objective 4 below).

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[1] Network data is for April 1999; enrollment data is for June 1999.

[2] One organization served as a sub-contractor to another MCO in year one, but began to directly contract with the State in year two.

1.4 *To build managed care capacity in Oklahoma's rural communities, and to test various alternatives for creating this capacity in order to identify the most effective model(s).*

At the start of the ***SoonerCure*** demonstration, managed care was virtually non-existent outside of the three metropolitan communities of Oklahoma City, Tulsa, and Lawton. Providers in rural communities had no experience with capitation, nor with the type of contractual obligations (e.g., 24-hour/7-day coverage) typically found in managed care contracts.

Recognizing this lack of experience, the State elected to introduce managed care to rural Oklahoma by initially contracting directly with primary care physicians and paying capitation for primary care office visits, a small number of ancillary services (lab tests and X-rays), and case management (the ***SoonerCare Choice*** model). Capitation rates were adjusted by age/sex and aid category and included both a medical and case management components. The Oklahoma State Medical Association was permitted to review the methodology used to set the rates and ultimately issued a public endorsement to its membership. Subsequently, the State now also contracts with advanced practice nurses and physician assistants as providers.

In return for receiving capitation, providers were required to sign a much more comprehensive contract than had existed under the fee-for-service program. The new contract included specific service accessibility, outreach, case management, and referral standards. Subsequent contracts in years two through four have gradually added requirements for providers and raised initial targets for EPSDT compliance from 60 to 80 percent. At the time of the program's inception, providers expressed wariness about capitation and about contracting with the State. However, ***SoonerCure Choice*** has since grown steadily more popular, as indicated by a steady rise in the number of participating providers, and a stabilization in this network as year five approaches.

Looking forward, the State intends to build upon the success of ***SoonerCare Choice,*** rather than to supplant it with the MCO model. The State is actively exploring the feasibility of contracting with one or more management service organizations (MSOs)[3] to establish a more comprehensive model in rural Oklahoma. These MSOs would manage the PCP/CM network in their areas, facilitating referrals to specialists and tertiary providers. They also could be used to administer contracts with a Pharmacy Benefit Manager and/or Behavioral Health and Transportation contractor, each of which would be capitated for their respective benefits.

The MSO concept could be accommodated under the existing ***SoonerCure*** waiver, as it conforms closely to the "Comprehensive Outpatient Network" model described in the original proposal. However, before proceeding the State would provide information in much greater detail to HCFA through a modification of the operational protocol.

[3] **Also known as Administrative Service Organizations,** or **ASOs**.

1.5 *To more closely align rural providers with their urban counterparts, so that rural Title XIX beneficiaries are better able to obtain access to needed specialty/referral services.*

One of the purposes of the MSO model, as described above, would be to offer primary care providers in rural Oklahoma a referral pipeline that does not currently exist. The groundwork for this pipeline has been laid, through another component of the Rural Partnership initiative.

In 1997-1998, the State solicited proposals and negotiated with two MCOs to establish "rural referral networks" for PCP/CM providers. Specifically, the MCOs would agree to open their own specialist networks to PCP/CMs, permitting the physicians to arrange specialty care visits and procedures through the MCOs' medical management departments. The MCOs would commit to arranging referrals/specialty services using ***SoonerCare Plus*** accessibility (appointment timeliness) standards.

'While the State did not immediately move in 1997-1998 to put the rural referral networks in place, it has continued to explore the concept with the two interested plans. The State anticipates that the model might be folded into the broader MSO concept, if that is pursued, or implemented independently sometime in the future.

1.6 *To enhance the ability of rural communities to retain existing providers and attra new ones.*

One of the long-term hopes for ***SoonerCare Choice*** is that it will encourage providers to remain or move into rural areas, by offering an attractive patient base and revenue source. It is too early in the program's history to draw conclusions about its effect on overall physician supply (as opposed to Title XIX participation, which is increasing). However, the State has managed to stretch the existing capacity of rural providers through ***SoonerCare Choice*** in a number of ways:

- The State has implemented a 24-hour nurse advice line for rural beneficiaries, providing an important back-up to PCP/CM providers. The advice line's availability has been a significant aid in recruiting providers and demonstrating the State's commitment to supporting their rural practices in meaningful ways.

- Through the guarantee of patients and an associated capitation revenue stream, the State has provided the capital necessary for a number of providers to expand their practices, both through the hiring of non-physician practitioners (e.g., physician assistants) and other methods. One of the largest rural providers, the Konawa Community Health Center (a Federally Qualified Health Center), has expanded its operations into medically under-served neighboring counties through acquisition of two mobile clinics and a satellite facility.

- In very rural areas, the State has contracted directly with advanced practice nurses who operate under protocol agreements with physicians and serve as PCP/CMs. Prior to the demonstration, this was not an option for the State.

1.7 *To better integrate Title XIX beneficiaries, including long term care recipients, with the privately insured population, through enrollment into managed care delivery systems serving both populations.*

During the last two-to-three years, Medicaid managed care programs nationally have been confronted with an exodus of commercial MCOs, leaving Medicaid-only plans as the sole option available to beneficiaries in some areas. Thus far, Oklahoma has not encountered this problem. The State contracts with four commercial MCOs, two of which enrolls only Medicaid beneficiaries. At least one commercial plan is under contract in each service area, allowing members to select this option if they so desire.

Perhaps more importantly, the State has made dramatic progress toward integrating historical Title XIX providers with their counterparts practicing in commercial health plans. Prior to the start of the demonstration, the State published lists of "traditional" providers (based on historical volume of care furnished) in a wide array of service categories, including: primary care and specialist physicians, community health centers, behavioral health providers, pharmacies, DME suppliers etc.

MCOs were required to enter into good faith negotiations with any traditional providers who asked to join their networks. Many of these providers had remained completely outside of the managed care networks prior to ***SoonerCare*** and so took advantage of this opportunity to form relationships with the health plans, both for Medicaid and commercial patients. For example, before the waiver, none of the State's four urban FQHCs had managed care contracts. After the waiver, all had contracts with the MCOs in their service areas. Today, the FQHCs serve as significant PCP sites for ***SoonerCare Plus*** and also have bolstered their commercial patient bases.

The relationships formed in year one have proven to be permanent. Even after the traditional provider requirements were lifted in 1997, the MCOs retained the traditional providers in their networks, with little attrition.

With respect to long term care, the ***SoonerCare*** waiver contained a "conceptual" chapter addressing the enrollment of this population, but did not seek authority to do so. Per legislative mandates, the State is presently working on the development of one or more pilot programs that may be voluntary, and would seek to enroll the long-term care population and/or Medicaid/Medicare dual eligibles into fully integrated systems of care. These voluntary pilots would begin in July 2000 at the earliest, and would serve as the starting point for development of a mandatory waiver program. Any waivers necessary for the mandatory program would likely be requested in the first half of calendar year 2000.

1.8 *To instill a greater degree of budget predictability into Oklahoma's Title XIX program, by moving from a fee-for-service program to one based on the concept of pre-payment.*

Oklahoma's decision to seek a §1115(a) R&D Waiver was partly due to the fiscal crisis the State faced in the early 1990's. While other states used the demonstration option as

a means to expand Title XIX eligibility, Oklahoma' initial goal was to achieve sufficient fiscal stability to avoid further cutbacks to the fee-for-service program.

Soonercare has been successful in achieving necessary budget predictability and in moderating the growth in medical costs. The State estimates that it saved $85,203,996 in years one through three of the program (state and federal dollars) or 9.09 percent of total expenditures. More detailed information regarding budget neutrality and waiver savings is provided in section six, *Compliance with the Budget Neutrality Cap*.

2. Terms and Conditions

Oklahoma believes it is in full compliance with all waiver Special Terms and Conditions. Because of their length, the Terms and Conditions are not reprinted here. However, the State's demonstration of compliance is presented in the same order (and using the same numbering scheme) as found in the original HCFA document. Additionally, the information detailing Oklahoma's compliance with the requirements listed in the Special Terms and Conditions is provided in annual and quarterly reports submitted to HCFA.

2.1 General Conditions:

1. Prior Approval of "*" Items. The State has submitted, and received prior approval, of all "*" items in the Terms and Conditions.
2. Pre-Implementation Work Plan. The work plan was submitted and approved by HCFA.
3. Protocol. The operational protocol was submitted to HCFA October 12, 1995 with all required chapters. Subsequent revisions have been submitted and approved.
4. Phase-Out Plan. As the program is not within six months of termination, this requirement does not yet apply.
5. Compliance with the following are addressed in further detail in the appropriate following sections:

- Requirements for Federal Financial Participation
- General Administrative Requirements
- General Reporting Requirements
- Monitoring of Budget Neutrality
- Access Standards
- Outline for Operation Protocol

2.2 Legislation:

Compliance with Federal Law. The State has complied with all requirements of the Medicaid program not expressly waived for the ***Soonercare*** program, including changes that have occurred since October 16, 1995.

2.3 *Program Design/Operation Plan:*

(A) Subsumed §1915(b) Waiver

Upon commencement of the §1115(a) R&D Waiver, effective January 1, 1996, the State's §1915(b) waiver was subsumed in the §1115(a) R&D waiver. Oklahoma has met the requirements outlined in the Terms and Conditions Attachment D; section titled *Projecting Per Member/Per Month (PMPM) Cost, Removing $1915(b) Managed Care Savings from AFDC-Urban PMPM Cost Estimates.*

(B) Capitation Rates

Oklahoma annually submits for HCFAs approval, all capitation rates, fee-for-service upper payment limits from which the rate ranges are derived for the health plans, and the methodology for determining the fee-for-service upper payment limits for services. All capitation rates, upper payment limits, and the methodology for determining the upper payment limits have been submitted to **HCFA** and found to be satisfactory.

(C) Rural Partners

The Rural Partner initiative was developed to assist rural areas of the State in gaining greater access to resources available through ***SoonerCare Plus*** MCOs, including advanced technology and specialty and sub-specialty services.

When the waiver became effective, the service area boundaries for the three catchment areas were drawn in such a way as to ensure that all MCOs serving urban areas also met specific "Rural Partner" criteria., This was planned to ensure that all affected rural beneficiaries and providers received the benefit of continuity of care available under the §1115(a) R&D Waiver. Specifically, MCOs were required to contract to serve at least 500 rural beneficiaries in each urban catchment area, or a number equal to 10% of their urban enrollment under the previous year, whichever was greater. The contracts signed by all MCOs actually established expansions, which far exceeded either the requirement that the expansion include at least 500 rural beneficiaries in each catchment area or that 10% of the MCOs' urban enrollments under the previous year be enrolled.[4]

(D) Plan Contracting

1. Use of Request For Proposal (RFP) Process. The State has used an annual RFP process to select health plans since the inception of the program. During the past four years, the RFP process has evolved from one in which health plans provided written documentation of their ability to comply with program standards, to one in which the operational compliance of incumbent plans is considered in award decisions.

[4] **The participating health plans were certified as "Rural Partners" through HCFA's approval of the MCO contracts, became eligible on July 1, 1996 (when their service areas expanded) and were certified as of that date.**

Under the current process, the Authority conducts operational compliance audits each fall to evaluate each plan's performance in meeting program standards. The audits generally cover the full range of health plan operations, including administrative/management, enrollment/member services, networks/provider services, quality assurance/medical management, information systems/claims payment, and financial solvency.

Plans that meet the standards for an operational area are waived from corresponding questions in the RFP. Conversely, plans that are found to be deficient must submit a Corrective Action Plan as part of their RFP responses (due to the State in April). Plans are not eligible for a contract until they demonstrate an ability to comply with all program standards. Following preliminary contract awards, the State conducts follow-up Readiness Reviews to evaluate the plans' ability to meet any new requirements for the coming contract year, as well as to verify implementation of Corrective Action Plans. Site visits are also made to major sub-contractors, where appropriate.

In addition to implementing a performance-based procurement, the State has modified its auto-assignment criteria from one based solely on price (with the least-costly plan receiving the highest percent of auto-assignments) to one based equally on price and technical performance, as measured by the number of points awarded for the plan's technical proposal.

Once the initial auto-assignment ratio is established, the State conducts a "look-back" at plan performance with respect to EPSDT. Plans that performed below the established performance threshold during the previous year (assuming they were contractors) receive a lower rate of auto-assignments going forward. For example, if a plan under-performed by 10 percent, its auto-assignment rate is lowered by 10 percent. Each year the State has increased the minimum EPSDT compliance threshold; the current threshold is set at 80 percent.

2. Prior Approval. All RFPs have been submitted to HCFA for review and approval.

3 Model Contracts and Marketing Materials. All model contracts have been submitted to HCFA for review and approval. The State has established a process for prior-approval of marketing materials used by health plans. From the beginning of the program, the State has prohibited direct marketing, limiting health plan activities to general outreach and distribution of printed materials in the enrollment packets. Please see Chapter 5 of the §1115(a) R&D Waiver Protocol for more information on the State's marketing and outreach policies and procedures.

4. Provider Capacity. The State's procedures for determining the adequacy of managed care provider capacity are described in Chapter **2** of the §1115(a)

R&D Waiver Protocol. Since the inception of ***SoonerCare,*** the State has implemented a sophisticated methodology for evaluating provider capacity. Health plans submit network information electronically, allowing the State to merge databases and eliminate duplication across networks, as well as to plot provider locations against beneficiary locations using GeoACCESS.

The State submits annual reports on the status of waiver operations. The annual reports contain detailed information on access to care, including any significant changes in provider networks. To date, there have not been any significant decreases to report. The State is able and willing to provide addresses of members and providers to HCFA, if so requested. As delineated in the protocol, the State has implemented managed care in both urban and rural areas only after being able to demonstrate that sufficient provider capacity exists.

5. Disclosure Requirements. The disclosure requirements specified at 42 CFR 455, Subpart B were met prior to the start date of the waiver.

(E) Streamlined Eligibility

Streamlined Eligibility. Oklahoma received a waiver of retroactive eligibility, subject to submitting and receiving approval of a "real time" streamlined eligibility process. The State subsequently elected not to implement this provision and has not submitted a "real time" plan to HCFA.

(F) Family Planning

Title X provisions are outlined in the Oklahoma's §1115(a) R&D Waiver Protocol, section *12. Inclusion of Family Planning Services in* ***SoonerCare.*** Additionally, Oklahoma includes language in annual ***Soonercare*** contracts that provides assurances that access to these services, by adolescents, are not restricted by the §1115(a) R&D Waiver. Currently, no amendments have been made to the Title X agreement as a result of the demonstration.

(G) Health Services To Native American Populations

Chapter 11 of the §1115(a) R&D Waiver Protocol addresses services to Native Americans. Since the start of the program, the State has continued to work with various tribes, urban Indian clinics, and the Indian Health Service (IHS) to identify ways to increase Native American provider and beneficiary participation in ***Soonercare.*** The State also has enrollment data on the Native American population and is prepared to make the data available to Indian Health programs upon request.

Initially, the IHS and tribal clinics elected not to contract with the health plans in the ***Soonercare Plus*** and ***Choice*** areas. However, during the last few months several tribal and IHS facilities have requested that the State re-evaluate participation options and work with these providers to develop a model which would allow them to serve as PCP/CMs in the ***SoonerCare Choice*** program. The

State is currently developing this model with tribal and IHS input and hopes to put it into effect later this year.

(H) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services
Included in Oklahoma's § 1115(a) R&D Waiver Protocol, section ***4. SoonerCare*** *Benefits Package and EPSDT Initiative,* is an approved comprehensive plan, which outlines services, outreach, and preventive care. Oklahoma has included language in the annual ***SoonerCare*** contracts that provides assurances that access to these services are consistent with the approved plan outlined in the protocol. Specifically, under ***SoonerCare Plus,*** health plans are penalized through lower auto-assignment rates for failing to meet the State's EPSDT performance benchmark (see Term & Condition "D" above). Under ***SoonerCare Choice,*** providers are eligible for incentive payments if they exceed the State's performance benchmark (see Objective #1 above). Additional information on the State's EPSDT monitoring and compliance efforts is also provided in section *5, Quality.*

In addition to these compliance guidelines, the State has initiated an ambitious project in conjunction with the Oklahoma State Department of Education (OSDE) for enhanced EPSDT school-based services. This effort, which is being carried out in coordination with ***SoonerCare,*** provides for the seamless provision of services to Medicaid children across a variety of providers. Through it, the State has increased both the presence of and the provision of appropriate school-based EPSDT services to Medicaid children, both in managed care and in fee-for-service. Contracts with school districts and school district co-ops have 'been developed, as have joint training programs.

The EPSDT focused study for Year III (July 1, 1997 through June 30, 1998) shows a marked improvement from a Year I combined rate of 40% to a Year III combined rate of 48%.

(I) Federally Qualified Health Centers

1. Contracting. MCOs are required to contract with at least one FQHC in each service area, assuming one exists (there is no FQHC in the Lawton region). In addition, MCOs are required to assign to the FQHCs any enrollees with whom they have not established contact (e.g. visit with a provider, face-to-face contact, or telephone contact) within 90 days of the effective date of enrollment. The FQHCs then are responsible for initiating additional outreach efforts to establish contact with these patients. In return for this outreach activity, the State makes a direct supplemental per member per month payment to FQHCs for each member who selects or is assigned to them for primary care. This supplemental payment program is scheduled to phase-out June 30, 1999. However, the State is currently negotiating, with HCFA, a new FQHC supplemental payment program that would provide additional funds which will contribute to the continued viability of the FQHC safety net providers in a managed care environment.

2. Exemption from Contracting with FQHCs. Not applicable. Under their contracts with the State, MCOs cannct request exemption from the requirement to include at least one FQHC in their network per service area.
3. Payment to FQHCs. At the start of the waiver program, the Oklahoma Primary Care Association, acting on behalf of the State's FQHCs, negotiated an agreement with the State concerning FQHC payments ***(SoonerCare Plus*** program). The payments were made "cost-related" through introduction of a supplemental PMPM amount given directly by the State to FQHCs, in addition to the fee-for-service or capitated payments they receive from MCOs. The agreement was approved by HCFA prior to implementation.
4. The ***SoonerCare Choice*** program contracts with all FQHCs. Rather than a supplemental payment the ***Choice*** program pays an enhanced capitation rate to these centers.

(J) Encounter Data Requirements

Included in Oklahoma's §1115(a) R&D Waiver Protocol, section ***9.*** *Encounter Data Collection and Reporting,* is an approved comprehensive plan, which outlines a process for the collection of encounter data and its use in improving the efficiency and quality of health care for the Title XIX recipients. Additionally, Oklahoma includes language in the ***SoonerCare*** annual contracts that provides assurances that encounter data is submitted to the OHCA on a monthly basis by electronic medium in a format prescribed by law. Failure on the part of individual plans to comply with encounter data reporting requirements can result in sanctions, including the freezing of enrollment into the plan. The State will be conducting its first encounter data validation study this year using a methodology developed by the Medstat Group.

Currently, the volume of encounters submitted by the MCOs remains below the anticipated volume. Some of the MCOs still experience difficulties in formatting and processing NCPDP (pharmacy) claims. Concentrated efforts are now made by the agency to assist the MCOs in any way necessary to insure that all pharmacy claims are processed in a timely manner. Changes are also being implemented to limit exceptions on all encounters to a minimum. The most recent change made to encounter processing is one that allows MCOs to zero bill for charges that they reimburse at a flat rate, consequently no charge information is created. The system defaults the encounter amount to the procedure code price for future use in calculating rates.

In addition to collecting encounter data, the State has required MCOs to collect and report HEDIS measures, working in concert with Oklahoma's external quality review organization (EQRO), the Oklahoma Foundation for Medical Quality. Detailed information on the State's efforts with respect to monitoring quality is provideu in section 5 of this waiver extension request.

(K) Quality Assurance Requirements

1. Monitoring Plan. Refer to section 5, *Quality.*

2. Monitoring Beneficiary Satisfaction. Refer to section 3, *Evidence of Beneficiary Satisfaction.*

3. Quarterly Grievance Reports
The State researches and resolves provider and member incidents **and** complaints on a daily basis, however, MCOs are required to submit quarterly reports on all complaints and grievances. In addition to the quarterly reports, the State includes a more detailed review of plan complaint and grievance procedures during the annual operational compliance site visits. Plans that have not met State standards for documenting and processing complaints and grievances have been required to develop Corrective Action Plans in order to come into compliance. Effective July 1999, the State is implementing a new complaint/grievance reporting system that will capture MCO data in an automated format, using common definitions, and will allow for more sophisticated analysis and trending of plan performance.

4. Quality Assurance Standards. *Refer to section **5, Quality.***

5. Guidelines for Monitoring of Providers.
The State's contract with MCOs requires the plans to ensure their providers comply with all program standards. During its operational audits, the State reviews MCO-provider contracts to verify that appropriate binding language has been included. The State also evaluates how the MCOs monitor the performance of their providers to ensure compliance with program rules.

6. Access and Solvency Requirements.
The ***SoonerCare Plus*** health plans are in compliance with all of the requirements delineated in §1903(m)(1)(A)(I) and (ii), and §1902(w), including with regard to Advance Directives.

2.4 Attachments

(A) FFP/Cost Control/Fiscal Administration. Oklahoma continues to work on generating HCFA-64.9 and/or 64.9p reports that are consistent with the requirements outlined in the Special Terms and Conditions. During the May 1999 site visit, the State agreed to provide HCFA with quarterly managed care expenditure information' (by date-of-service and date-of-payment) dating back to the start of the waiver (January 1, 1996). The OHCA is currently working on a timeline for submission of this information. Expenditure information is included in the annual budget neutrality reports, however, it is not broken down by quarters nor does it reflect expenditures by date-of-service.

(B) General Administrative Requirements. The State has complied with the Protocol and Waiver Amendment requirements when making modifications to the

SoonerCare program. The State also has submitted Form HCFA-416 (EPSDT Compliance Rates) as required, as well as contracts related to the demonstration.

(C) General Reporting Requirements. The State has submitted all required quarterly and annual reports with the exception of the January through March 1999 report that was due May 31, 1999. The State intends to have this report to HCFA no later than July 31, 1999.

(D) Monitoring Budget 'Neutrality. The State has tracked and reported its performance with respect to budget neutrality in accordance with the instructions provided in Attachment D. Additional information regarding budget neutrality is provided in section 6, *Compliance with the Budget Neutrality Cap.*

(E) Access Standards. The State imposes the access standards delineated in Attachment E on its MCO contractors, and monitors compliance through evaluation of provider network counts/locations, undercover calls and complaint/grievance tracking.

(F) Outline for Operational Protocol. The operational protocol contains all of the chapters delineated in Attachment F.

3. Evidence of Beneficiary Satisfaction

The State has tracked beneficiary satisfaction with ***SoonerCare*** through two survey instruments: Behavioral Risk Factor Surveillance System (BRFSS) and Consumer Assessment of Health Plan Study (CAHPS). Additionally, the State has developed a template to summarize complaints and grievance data program wide and it is anticipated that this tool will begin producing program level data this summer.

3.I *Satisfaction Sur s:*

Behavioral Risk Factor Surveillance System (BRFSS)

BRFSS is a joint project between the Centers for Disease Control and Prevention and States to routinely collect behavioral risk factor information from that population. For SFY 96 and 97, information was collected from a sample of 300 randomly selected Medicaid eligible females age eighteen or older, who were enrolled in a Medicaid MCO for at least six months. The sample was selected monthly by the Medicaid agency and sent to the Oklahoma State Department of Health. The BRFSS survey consists of risk factors and demographic characteristics, indices of health plan satisfaction. The State drew upon the satisfaction measures in order to provide an assessment of health plan satisfaction for Medicaid managed care for the first two contract years.

Indices for satisfaction with health care were consistently high for SFY 96 and 97. Eighty-one percent of the respondents rated their health care good to excellent in SFY

96, with an increase to eighty-four percent in SFY 97. Utilization measures indicated that over ninety percent of the respondents were obtaining health care from one location or doctor, indicating a continuity of care. There was a decline in SFY 97 from SFY 96 in those respondents using school health clinics, centers, or other publicly funded sources of health care. This supported the goal of establishing a medical home for Medicaid recipients. More detailed information on the results of the BRFSS survey are available in the Annual Reports submitted to HCFA for 1996 and 1997.

3.2 Consumer Assessment of Health Plan Study (CAHPS):

CAHPS was developed by a consortium of Harvard Medical School, RAND, and Research Triangle Institute and sponsored by the Agency for Health Care Policy Research (AHCPR). CAHPS was designed to be an appropriate tool for assessing client satisfaction for Medicaid, Medicare, and commercial populations for both managed care and traditional Fee-for-Service. Oklahoma was involved with the CAHPS developmental process early, as a test site for the Medicaid CAHPS module. Oklahoma has sponsored the administration of both the original CAHPS in SFY 98 and the revised CAHPS 2.0 in SFY 99. Both the Child and Adult questionnaires were administered to samples from each health plan and the State operated partially capitated managed care program for each year the survey has been administered.

Report cards have been developed using CAHPS methodology for each year and disseminated during open enrollment. Survey ratings have also provided program direction for appropriate interventions. Results using the CAHPS format for analysis, stated in the positive and combined across plans and programs ***(Plus*** and ***Choice)*** types to give **an** overall picture of satisfaction with managed care, are as follows:

		SFY98	SFY99
• Ease in finding a provider with whom the customer is pleased	Adult	77.4%	83.3%
	Child	84%	89.7%
• Overall approval rate for providers	Adult	79%	82%
	Child	83%	84%
• Overall approval rate for health plan	Adult	74%	76%
	Child	78%	79%
• Getting care when needed	Adult	49%	70.8%
	Child	56.6%	79.4%
• Getting care without long waits	Adult	42.4%	44.1%
	Child	47.5%	49.3%
• Providers always communicate well	Adult	59.2%	65.2%
	Child	67.3%	70.8%

- Always treated with courtesy and respect — Adult 59.7% 75.6%; Child 66.1% 72.8%

- Customer service always efficient and helpful (98); or customer service not a problem (99) — Adult 44.9% 60.8%; Child 42.7% **63.2%**

Data indicate a consistent pattern of improvement across all areas assessed. While getting care without long waits remains a problem area, plans and providers consistently remain within contracted time frames for getting appointments and seeing patients. This may be related to patient perceptions and expectations rather than contractual reality.

Data also indicate consistently higher approval ratings for services to children than adults. The Medicaid program in general, including managed care, provides a greater array of services for children than adults. The child population served in managed care is also considerably larger than the adult population. These differences are probably reflective of program differences.

Medicaid recipient perception of services received through managed care remains high and indicates improvement throughout the measurement process. A more detailed plan specific presentation and technical report of each of these surveys can be found in the respective annual reports submitted to HCFA.

3.3 *Complaints and Grievances:*

The State collects complaints and grievance data from plans, as well as directly from beneficiaries through a ***SoonerCare*** helpline. The information is used as part of health plan audits but has not been summarized program wide. However, the State has recently developed a summary report template and will begin producing quarterly program level results this summer.

4. Documentation of Adequacy and Effectiveness of the Service Delivery System

The State uses a variety of tools to measure the effectiveness of the ***SoonerCare*** service delivery system. Separate methods are employed for the ***SoonerCare Plus*** and ***SoonerCare Choice*** components of the program.

4.1 *Plus (MCO) Program*

The State performs a comprehensive evaluation of MCO provider networks annually, as part of its contract award process. Health plans are required to submit detailed network information in an electronic format, separately for each provider type and service area. Plans not only submit provider names and addresses, but also "quality" related information, such as:

- Board Certification Status
- Office hours, by site and day
- Patient capacity
- Language capability
- Wheelchair accessibility
- Use of mid-level practitioners (e.g., nurse practitioners)

The State performs a sophisticated analysis of network data to quantify each plan's capacity, as well as to verify compliance with travel time/distance standards (in part relying on maps and GeoACCESS reports submitted by plans). Each plan must be able to demonstrate that it complies fully with program network/accessibility requirements. The State also combines network data across plans, to determine the unduplicated primary care provider capacity available to the program.

A template copy of the computer databases submitted by plans was included in the Year V RFP, submitted to HCFA on June 18, 1999 and is currently pending approval. The RFP also includes a copy of the tool applied by the State in evaluating the network data. Because of their size, the actual submissions received from each MCO during the most recent procurement are not included but were examined by HCFA evaluators during the March 1999 site visit.

The State verifies the accuracy of network proposal information submitted by plans during its semi-annual on-site audits. Plans are furnished with a randomly selected list of providers from their network submissions and asked to produce contract and credentialing files. These files are reviewed to ensure the contracts are in place and that other information submitted in the proposal (e.g., regarding Board status) is correct.
The State monitors changes in plan networks through monthly reports submitted by the MCOs. The reports document additions or deletions from the network. Plans are further required to notify the State immediately of any "material" changes that occur in their networks, such as the loss of a contracted hospital or major physician group. If a negative material change occurs (or through attrition a network deteriorates significantly over a period of several months), the State can freeze enrollment, terminate the contract, or order other corrective action as appropriate.

4.2 Choice (PCP/CM) Program

The State serves as the de facto "health plan" for the PCP/CM program and therefore monitors network capacity on an on-going basis. The State maintains provider counts, by specialty, provider type and region. The State also produces maps delineating provider locations to verify travel time/distance standards can be met for all beneficiaries. The State produced network materials for HCFA to examine during the site visit conducted in March 1999.

Additionally, the State requires providers to submit information on Board Certification Status, office hours by site, patient capacity, language capabilities, use of mid-level practitioners, hospital admission information, and access to care after hours.

5. Quality

The State performs extensive quality improvement activities for ***SoonerCare*** in collaboration with its External Quality Review Organization (EQRO). Specific activities are described below.

5.1 *QARI Monitoring:*

SoonerCare Plus - OHCA selected the Quality Assurance Reform Initiative (QARI) as the quality monitoring tool for the $1115(a) R&D Waiver. The state contracted with The Oklahoma Foundation for Medical Quality as the EQRO for QARI implementation. The Third Annual QARI review submitted to HCFA in the SFY 98 Annual Report provides more detail on cumulative QA activities and should be consulted for more specific information. Focused studies were included in the third and fourth quarter HCFA reports for the same year and should also be consulted for more detailed information.

The QARI review results for each MCO serves as the implementation plan for the following year. Plans not at 80 percent compliance with QARI for any element were scheduled for a more intensive follow-up review at six months. The purpose of the review and any follow-up was to provide assistance in facilitating full compliance. All plans have made substantial progress in implementing QARI. The following is the status of QARI Implementation for participating MCOs as of SFY 98; SFY 99 results will be available upon completion of the SFY 99 Annual Report to HCFA:

Standard I: Written QAP
All plans were at substantial to full compliance.

Standard 11: Systematic Process of Quality Assessment and Improvement
All plans were at substantial to full compliance.

Standard 111: Accountability to Governing Body
All plans were at substantial to full compliance.

Standard IV: Active QA Committee
All plans were at substantial to full compliance.

Standard V: Supervision
All plans were at substantial to full compliance.

Standard VI: Adequate Resources:
Four of the five plans were at substantial to full compliance. Prime Advantage was not at 80 percent compliance, so follow-up monitoring at six months took place. The plan was reported at full compliance.

Standard VII: Provider Participation in the QAP
All of the plans were at full compliance

Standard VIII: Delegation of QAP Activities
All of the plans were at full to substantial compliance.

Standard IX: Credentialling and Recredentialling of Professionals
Four of the five plans were in substantial compliance. BlueLincs was not at the 80 percent threshold, so follow-up monitoring took place at six months. While improvement was indicated, the 80 percent threshold was not met. The plan will be reviewed during the SFY 99 annual review.

Standard X: Enrollee Rights and Responsibilities
Four of the five plans were in full to substantial compliance. Foundation Health would have been scheduled for follow-up monitoring had it remained a ***SoonerCare*** MCO for year IV.

Standard XI: Standards for Availability and Accessibility
Four of the five plans were in full to substantial compliance. Prime Advantage was not at the 80 percent threshold, so follow-up monitoring took place at six months. The plan was at full compliance.

Standard XII: Medical Records Standards
Four of the five plans were in substantial compliance. BlueLincs was not at the 80 percent threshold, so follow-up monitoring took place at six months. Improvement was not noted. The plan was cited for note during the contract award process. The plan will be reviewed during the SFY 99 annual review.

Standard XIII: Utilization Review
Three of the five plans were in full compliance. Prime Advantage was not at the 80 percent threshold, so follow-up monitoring took place at six months. While considerable improvement had taken place, the plan was just short of the 80 percent threshold; the plan will be reviewed during the SFY 99 annual review.

Standard XIV: Continuity of Care System
Four of the five plans were in full compliance. Prime Advantage was not at the 80 percent threshold, so follow-up monitoring took place at six months. While improvement had taken place, the plan was just short of the 80 percent threshold; the plan will be reviewed during the SFY 99 annual review.

Standard XV: *QAP* Documentation
Four of the five plans were at substantial to full compliance. Since Prime Advantage had areas for improvement to reach an 80 percent threshold, follow-up monitoring took place at six months. While considerable improvement had taken place, the plan was just short of the 80 percent threshold; the plan will be reviewed during the SFY 99 annual review.

Standard XVI: Coordination of QA Activity with other Management Activity
All plars are at substantial to full compliance.

While full compliance with QARI has not yet occurred in all areas, there has been substantial progress. Plans in full compliance for two monitoring years were not reviewed for those element in future years. Plans with NCQA or JCAHO accreditation were not reviewed for comparacle QARI elements, but the comparable elements were incorporated into the QARI scores.

SoonerCare Choice - In keeping with the Quality Assurance plan for the agency's §1115(a) R&D Waiver, the State actively monitors the partially capitated, Primary Care Provider/ Case Management Program. The State uses eight areas for quality monitoring and adapted relevant QARI elements as monitoring tools. The categories for monitoring which were selected and the relevant QARI elements are as follows:

1. Provider Enrollment and Education - QARI I-E, IV-E IX, and X-C
2. Client Enrollment and Education - QARI X
3. Access - QARI X-G and XI
4. Primary Care Services - QARI XIII and II
5. Specialist Serviced Referrals - QARIXIII-ABC
6. Client Satisfaction/ Grievance Procedures - QARI X-K
7. Medical Records - QARI XII
8. Utilization Management - QARI XIII

For a detailed account of the ***SoonerCare Choice*** QARI Review, refer to SFY 98 HCFA Annual Report documentation. The following are ratings from the EQRO, with recommendation for improvement in follow-up areas:

1. Provider Enrollment and Education - 4.34 Substantial compliance, with no follow-up monitoring.
2. Client Enrollment and Education - 4.52 Substantial compliance, with no follow-up monitoring.
3. Access - 4.5 Substantial compliance, with no follow-up monitoring.
4. Primary Care Services - 3.28 Recommendation for six month follow-up monitoring. While improvement had taken place, the program was below the 80 percent threshold; the program will be reviewed during the SFY 99 annual review.
5. Specialist Services/ Referrals - 3.39 Recommendation for six month follow-up monitoring. While improvement had taken place, the program was below the 80 percent threshold; the program will be reviewed during the SFY 99 annual review.
6. Client Satisfaction/ Grievance Procedures - 5 Full compliance, with no follow-up monitoring.
7. Medical Records - 4.07 Recommendation for six month follow-up monitoring. While improvement had taken place, the program was below the 80 percent threshold; the program will be reviewed during the SFY 99 annual review.
8. Utilization Management - 3.67 Recommendation for six month follow-up monitoring. While improvement had taken place, the program was below the 80 percent threshold; the program will be reviewed during the SFY 99 annual review.

SFY 99 will be the last year that the State will use QI RI as a monitoring too The State will begin QISMC implementation during SFY 2000.

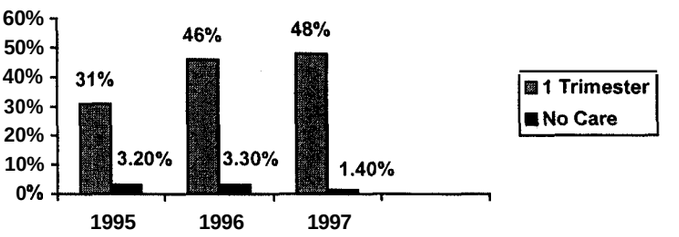
5.2 *Focused Studies:*

Focused Study Information - The Focused Study results for ***SoonerCare Plus*** and ***Soonercare Choice*** have been released for Calendar Year 1997. The ***SoonerCare*** *Plus* focused studies were for Pregnancy and Birth Outcomes, EPSDT, Immunizations, and Pediatric Asthma. The ***SoonerCare Choice*** focused studies were for EPSDT and Immunizations. A brief description of the ***SoonerCare*** focused studies appears below, including the ***SoonerCare Choice*** focused studies for EPSDT and Immunizations. More detailed information on the focused studies is available in the third and fourth quarter HCFA reports for SFY 98. SFY 99 reports are not yet available.

The focused studies represent a more in depth review than would otherwise be available through claims data. The basis for the studies is sampling from all eligibles and a medical records review for each eligible sampled. This provides a more detailed account of services provided than would be available from claims data. Claims data were also reviewed for the individuals sampled.

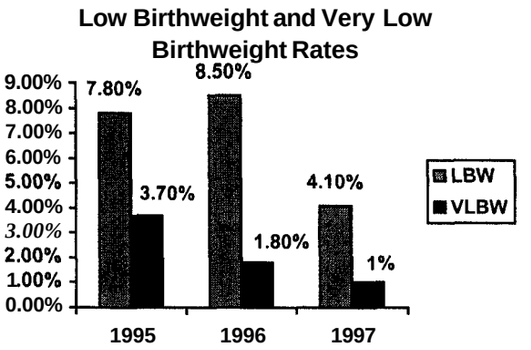
Pregnancy and Birth Outcomes Focused Studies - The Pregnancy and Birth Outcomes Focused Study for ***Soonercare Plus*** provides outcomes on initiation of prenatal care and low birth weight. Overall the rate of initiation of prenatal care in the first trimester has increased from 31 percent in 1995, to 46 percent in 1996, to 48 percent in 1997. The overall instance of no prenatal care has dropped from **3.2** percent to 1.4 percent. Over 75 percent of these women had initiated prenatal care prior to becoming ***SoonerCare*** members. This indicates continuity of care in movement to ***Soonercare.***

First Trimester Initiation of Prenatal Care

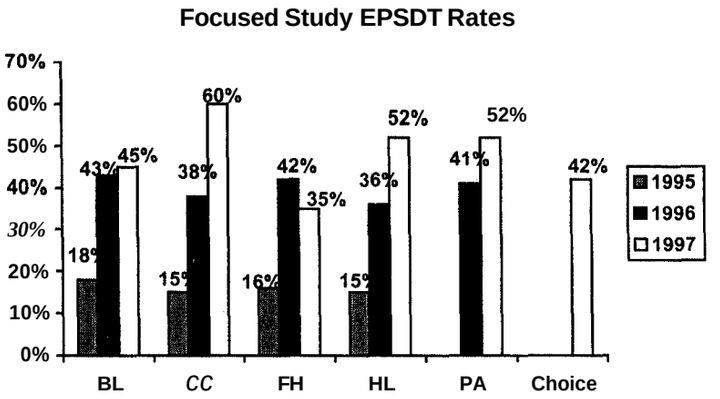


Low birthweight is a recommended monitoring element by HCFA. Low birthweight is, however, a difficult element to monitor through sampling due to the low occurrence. Low and very low birthrates have declined over the three-year period of the focused studies. Low birthrate is defined as 1500 grams to less than 2500 grams and very low birthrate is less than 1500 grams. The very low birthweight rate of 1 percent for 1997 represents a decline in the very low birthweight from 1.8 percent for 1996 and 3.7 percent for 1995. The low birthweight rate of 4.1 percent for 1997 represents a decline

from the 8.5 percent for 1996 and the 7.8 percent for 1995 The low and very low birthweight rates are fairly equitably distributed across plans with CommunityCare and Heartland having slightly higher rates.

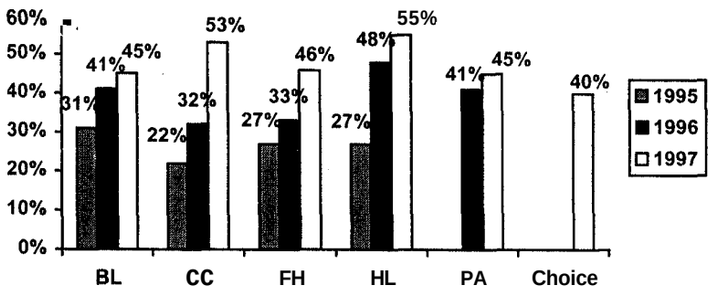


EPSDT Focused Studies Including *SoonerCure Choicefor 1997* - EPSDT rates are increasing within the ***SoonerCure Plus*** program and are at **42** percent for the initial phase of the ***SoonerCure Choice*** program. Medical records were checked for evidence of the two requirements for EPSDT: a comprehensive health and development history and an unclothed physical. The rates were at a low of 15 percent in 1995, but have increased to 60 percent in one plan in 1997.



Immunization Focused Studies Including *SoonerCare Choicefor 1997* - The results of the Immunization focused studies indicate an overall improvement for immunizations, with initial rates for ***SoonerCare Choice*** at 40 percent. There remains, however, considerable variation in the immunizations themselves. Immunizations that are a part of a series have lower rates and immunizations that are administered once or in combination, have higher rates.

Focused Study Immunization Rates



6. Compliance with the Budget Neutrality Cap

Attachment A (Savings – Aggregate Expenditure Comparison) and Attachment B (Savings - Per Member Per Month Cost Comparison) provide a complete overview of budget neutrality calculations for the period of January 1, 1996 through December 31, 2003.[5] **As** demonstrated in Attachments B and C, Oklahoma's waiver program costs for the period of January 1, 1996 through December 31, 2003 are estimated to be 90.93 percent of the fee-for-service equivalent, thereby demonstrating savings versus fee-for-service. The total savings over the entire period of the waiver amount to $373,515,528 (9.07%), of which $261,460,869 accrue to the Federal government and $112,054,658 to the State.

6.1 Aid to Families with Dependent Children (AFDC) and Related Medicaid Eligible Group:

WY-96 through WY-98 expenditures and eligible months are based on actual data. The remaining waiver years (1999 through 2003) expenditure estimates were derived using WY-98 cost data trended forward by 6.51 percent (the trend factors defined in the Special Terms and Conditions for this population). Eligible member months for WY-99 through WY-03 have been set equal to the WY-98 data, reflecting the similar enrollment characteristics.

6.2 Aged, Blind and Disabled (ABD) Medicaid Eligible Group:

Under the Special Terms and Conditions Oklahoma is authorized to mandatorily enroll the non-long term care portion of its ABD population. The State will begin enrollment July 1, 1999, however, the State must consider payments made during the entire waiver year when calculating budget neutrality. Due to the lack of current data the State used base year' upper payment limits to estimate expenditure/actual PMPM costs for WY-99

[5] Upper payment limits for waiver years 1996 through 2000, at HCFA request, have been adjusted to reflect a "weighted' average cost per group. The updated information has been included in Waiver Year III (Calendar Year 1998) Budget Neutrality Report, submitted on June 30, 1999.

[6] See *WY-96* ***Budget Neutrality Report*** for base year calculations methodology.

through WY-03. Eligible member months, for this same period of time, are set equal to State Fiscal Year 1997 fee-for-service enrollment data (374,693 member months).

7. Adequacy of Financing and Reimbursement

Oklahoma's Title XIX/XXI appropriation and projected rate of expenditure for Fiscal Year 2000 is $1,185,178,496. This demonstrates that the program is adequately financed, for the current fiscal year. The Legislature has not yet acted on the budget for Fiscal Year's 2001 through 2004.

B. PUBLICE NOTICE

1. The Public Notice below was placed for two (2) days in: the Daily Oklahoman (May 21, 22, 1999), the Lawton Constitution (May 23, 24, 1999), and the Tulsa World Newspaper (May 21, 22, 1999).

Public Notice

As provided for by Section 4757 of the Federal Balanced Budget Act of 1997, the Oklahoma Health Care Authority intends to file an extension, with the Health Care Financing Administration, on its present §1115(a) Research and Demonstration Medicaid Wavier. This extension would allow the State to operate its ***SoonerCare*** Program through December 31,2003. Without this Extension, the ***SoonerCare*** Program is scheduled to sunset as of December 31,2000.

This Waiver Extension will be discussed at the Oklahoma Health Care Authority Board Meeting, to be held on Thursday, June 3, 1999, beginning at 1:30 p.m. at the First Southwest Bank of Frederick, 201 S. Main - Conference Center, Frederick, Oklahoma 73542.

Comments related to this proposed Extension filing can be submitted to: Matt Lucas, Programs Design and Evaluation Director, Oklahoma Health Care Authority, 4545 North Lincoln Boulevard, Suite 124, Oklahoma City, Oklahoma 73015, or they may be Faxed to: (405) 530-7715. Individuals needing additional information may call: (405) 530-3303.

2. The State used several regularly scheduled meetings to serve as mechanisms to consider this Waiver extension request. To date, the State has not received comments or questions regarding the filing of this extension and will continue to monitor and forward any correspondence received within the next thirty (30) days. The meetings and dates are as follows:

▪ Health Plan Readiness Reviews:	Community Care	-	May 21, 1999
	Heartland	-	May 25,1999
	Bluelincs	-	May 26, 1999
	Prime Advantage	-	May 27, 1999
▪ The Oklahoma Health Care Authority Board Meeting		-	June 03, 1999
▪ Oklahoma Primary Care Association Meeting		-	May 20,1999
▪ Region VI ACF/Tribal Roundtable Meeting			June 09,1999
▪ Tulsa Perinatal Coalition Meeting		-	June 14,1999
▪ Rural Health and DME Workshops:	Gordon Area VT	-	May 20,1999
	High Plains Area VT	-	May 24,1999
	Tulsa Technology	-	June 03,1999
	Kiamichi Vo-Tech	-	June 08,1999
	Durant Vo-Tech	-	June 10,1999
	Great Plains Area VT	-	June 16,1999
▪ Physician and Hospital Workshops:	Memorial Hospital	-	June 22,1999

ATTACHMENTS

Attachment A, pg.1 - Savings: Aggregate Expenditure Comparison Waiver Year 1996 Through 2003

Waiver Year I - CY1996 Savings = 8.97%

Comparison Groups	Expenditures	Eligible Months	PMPM Cost
WY 1996 Fee-For-Service Equiv.	$286,109,863	2,337,528	$122.40
WY 1996 Actual Expenditures	$260,439,055	2,337,528	$111.42
Total Saving WY 1996	($25,670,807)	-----	($10.98)
Federal Share	($17,969,565)	-----	($7.69)
State Share	($7,701,242)	-----	($3.29)

Waiver Year II - CY1997 Savings = 5.54%

Comparison Groups	Expenditures	Eligible Months	PMPM Cost
WY 1997 Fee-For-Service Equiv.	$297,593,610	2,282,744	$130.37
WY 1997 Actual Expenditures	$281,100,382	2,282,744	$123.14
Total Saving WY 1997	($16,493,228)	-----	($7.23)
Federal Share	($11,545,259)	-----	($5.06)
State Share	($4,947,968)	-----	($2.17)

Waiver Year III - CY1998 Savings = 12.15%

Comparison Groups	Expenditures	Eligible Months	PMPM Cost
WY 1998 Fee-For-Service Equiv.	$354,146,501	2,550,505	$138.85
WY 1998 Actual Expenditures	$311,106,540	2,550,505	$121.98
Total Saving WY 1998	($43,039,961)	-----	($16.88)
Federal Share	($30,127,973)	-----	($11.81)
State Share	($12,911,988)	-----	($5.06)

Waiver Year IV - CY1999 *Estimated* Savings = 9.04%

Comparison Groups	Expenditures	Eligible Months	PMPM Cost
WY 1999 Fee-For-Service Equiv.	$560,969,058	2,925,198	$191.77
WY 1999 Actual Expenditures	$510,250,615	2,925,198	$174.43
Total Saving WY 1999	($50,718,443)	-----	($17.34)
Federal Share	($35,502,910)	-----	($12.14)
State Share	($15,215,533)	-----	($5.20)

Waiver Year V - CY2000 *Estimated* Savings = 9.05%

Comparison Groups	Expenditures	Eligible Months	PMPM Cost
WY 2000 Fee-For-Service Equiv.	$596,279,429	2,925,198	$203.84
WY 2000 Actual Expenditures	$542,305,138	2,925,198	$185.39
Total Saving WY 2000	($53,974,291)	-----	($18.45)
Federal Share	($37,782,004)	-----	($12.92)
State Share	($16,192,287)	-----	($5.54)

Waiver Year VI - CY2001 *Estimated* Savings = 9.06%

Comparison Groups	Expenditures	Eligible Months	PMPM Cost
WY 2001 Fee-For-Service Equiv.	$633,817,674	2,925,198	$216.68
WY 2001 Actual Expenditures	$576,378,271	2,925,198	$197.04
Total Saving WY 2001	($57,439,403)	-----	($19.64)
Federal Share	($40,207,582)	-----	($13.75)
State Share	($17,231,821)	-----	($5.89)

Waiver Year VII - CY2002 *Estimated* Savings = 9.07%

Comparison Groups	Expenditures	Eligible Months	PMPM Cost
WY 2002 Fee-For-Service Equiv.	$673,724,677	2,925,198	$230.32
WY 2002 Actual Expenditures	$612,597,432	2,925,198	$209.42
Total Saving WY 2002	($61,127,245)	-----	($20.90)
Federal Share	($42,789,071)	-----	($14.63)
State Share	($18,338,173)	-----	($6.27)

Waiver Year VIII - CY2003 *Estimated* Savings = 9.08%

Comparison Groups	Expenditures	Eligible Months	PMPM Cost
WY 2003 Fee-For-Service Equiv.	$716,150,251	2,925,198	$244.82
WY 2003 Actual Expenditures	$651,098,102	2,925,198	$222.58
Total Saving WY 2003	($65,052,150)	-----	($22.24)
Federal Share	($45,536,505)	-----	($15.57)
State Share	($19,515,645)	-----	($6.67)

Waiver Year I-VIII, CY1996-2003 *Estimated* Savings = 9.07%

Comparison Groups	Expenditures	Eligible Months	PMPM Cost
WY 1996-2003 Fee-For-Service Equiv.	$4,118,791,063	21,796,767	$188.96
WY 1996-2003 Actual Expenditures	$3,745,275,535	21,796,767	$171.83
Total Saving WY 1996-2003	($373,515,528)	-----	($17.14)
Federal Share	($261,460,869)	-----	($12.00)
State Share	($112,054,658)	-----	($5.14)

Note:

1) Waiver Years 1996 through 1998 actual expenditures/eligible months include only the AFDC & Related Medicaid Eligible Groups.
2) Waiver Years 1999 through 2003 actual expenditures/eligible months include the AFDC & Related and the ABD Medicaid Eligible Groups.

Savings: Per Member Per Month Cost Comparison
Waiver Year 1996 through 2003

Waiver Year/MEG	Upper Payment PMPM Cost	Actual PMPM Cost	Savings
WY-1996:			
AFDC & REL. - Urban	$121.60	$113.36	6.78%
AFDC & REL. - Rural	$123.34	$109.19	11.47%
ABD Non-Inst. - Urban	$0.00	$0.00	0.00%
ABD Non-Inst. - Rural	$0.00	$0.00	0.00%
Average PMPM Cost Per Group	**$122.40**	**$111.42**	**8.97%**
WY-1997:			
AFDC & REL. - Urban	$129.52	$121.90	5.88%
AFDC & REL. - Rural	$131.37	$124.52	5.21%
ABD Non-Inst. - Urban	$0.00	$0.00	0.00%
ABD Non-Inst. - Rural	$0.00	$0.00	0.00%
Average PMPM Cost Per Group	**$130.37**	**$123.14**	**5.54%**
WY-1998:			
AFDC & REL. - Urban	$137.95	$123.53	10.45%
AFDC & REL. - Rural	$139.92	$120.37	13.97%
ABD Non-Inst. - Urban	$0.00	$0.00	0.00%
ABD Non-Inst. - Rural	$0.00	$0.00	0.00%
Average PMPM Cost Per Group	**$138.85**	**$121.98**	**12.15%**
WY-1999 - ***(Actual PMPMs are Projections):***			
AFDC & REL. - Urban	$146.93	131.57	10.45%
AFDC & REL. - Rural	$149.03	128.20	13.97%
ABD Non-Inst. - Urban	$536.14	$536.14	0.00%
ABD Non-Inst. - Rural	$427.26	$427.26	0.00%
Average PMPM Cost Per Group	**$191.77**	**$174.43**	**9.04%**
WY-2000 - ***(Actual PMPMs are Projections):***			
AFDC & REL. - Urban	$156.49	$140.14	10.45%
AFDC & REL. - Rural	$158.73	$136.55	13.97%
ABD Non-Inst. - Urban	$567.56	$567.56	0.00%
ABD Non-Inst. - Rural	$452.30	$452.30	0.00%
Average PMPM Cost Per Group	**$203.84**	**$185.39**	**9.05%**
WY-2001 - ***(Actual PMPMs are Projections):***			
AFDC & REL. - Urban	$166.68	$149.26	10.45%
AFDC & REL. - Rural	$169.06	$145.44	13.97%
ABD Non-Inst. - Urban	$600.82	$600.82	0.00%
ABD Non-Inst. - Rural	$478.81	$478.81	0.00%
Average PMPM Cost Fer Group	**$216.68**	**$197.04**	**9.06%**
WY-2002 - ***(Actual PMPMs are Projections):***			
AFDC & REL. - Urban	$177.53	$158.97	10.45%
AFDC & REL. - Rural	$180.07	$154.91	13.97%
ABD Non-Inst. - Urban	$636.02	$636.02	0.00%
ABD Non-Inst. - Rural	$506.86	$506.86	0.00%
Average PMPM Cost Per Group	**$230.32**	**$209.42**	**9.07%**

Waiver Year/MEG	Upper Payment PMPM Cost	Actual PMPM Cost	Savings
WY-2003 - ***(Actual PMPMs are Projections):***			
AFDC & REL. - Urban	$189.09	$169.32	10.45%
AFDC & REL. - Rural	$191.79	$164.99	13.97%
ABD Non-Inst. - Urban	$673.29	$673.29	0.00%
ABD Non-Inst. - Rural	$536.57	$536.57	0.00%
Average PMPM Cost Per Group	**$244.82**	**$222.58**	**9.08%**
Avg. PMPM Cost Per MEG/Per 1996-2003	**$188.96**	**$171.83**	**9.07%**

Actual PMPM Cost Calculations Explanation:

Aid to Families with Dependent Children and Related (AFDC & REL.) Groups

1) WY-96 through WY-98 expenditures and eligible months are based on actual data.
2) WY-99 through WY-03 expenditure estimates was derived using WY-98 cost data trended forward by 6.51 percent (the trend factors defined in the Special Terms and Conditions for this population).
3) Eligible member months for WY-99 through WY-03 have been set equal to the WY-98 data.

Aged, Blind, and Disabled (ABD) Group (non-institutionalized, non-dually eligible)

4) The State will begin enrollment July 1, 1999.
5) Base year[7] upper payment limits are used to estimate expenditure/actual PMPM cost for WY-99 through WY-03.
6) Eligible member months, for this same period of time, are set equal to State Fiscal Year 1997 fee-for-service enrollment data (374,693 member months).

[7] See ***WY-96 Budget Neutrality Report*** for base year calculations methodology.

GARTH L. SPLINTER, M.D., M.B.A.
CHIEF EXECUTIVE OFFICER

FRANK KEATING
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH **CARE** AUTHORITY

June 30, 1999

Ms. Sally Richardson
Center for Medicaid and State Operations
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Richardson,

Enclosed, please find Oklahoma's Annual Budget Neutrality Report for Waiver Year Three (WY-98) of the State's §1115(a) Research and Demonstration Waiver, Project Number: 11-W-00048/6-03. WY-98 covers the period of January 1, 1998 through December 31, 1998.

During WY-98 Oklahoma's waiver program Per Member Per Month (PMPM) costs were 87.85% of the Fee-For-Service (FFS) equivalent PMPM cost, thereby demonstrating savings versus FFS. The total saving for WY-98 amounts to $43,039,961 (12.15%), of which $30,127,973 accrues to the Federal government and $12,911,988 to the State. Accumulated saving for WY-96 through WY-98 totaled $85,203,996 (9.09%), of which $59,642,797 accrues to the Federal government and $25,561,199 to the State.

We have enjoyed very much working with both the Office of Research and Demonstration and the Regional Office staff. If you have any question or concerns about these documents, please call Matt Lucas at (405) 530-3273.

Sincerely

/s/

Mike Fogarty
Interim Chief Executive Officer
State of Oklahoma Medicaid Director

Cc: Joyce Jordan, Baltimore Central Office
Art Pagan, Dallas Regional Office
Tammy Auseon, Dallas Regional Office

BUDGET NEUTRALITY REPORT

SOONERCARE - PROJECT NUMBER 11-W-00048/6-03
WAIVER YEAR THREE (1998)

OKLAHOMA HEALTH CARE AUTHORITY
4545 N. LINCOLN BLVD., STE. 124
OKLAHOMA CITY, OK 73105

Compiled: 6/29/99

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Compiled: 6/29/99

§1115(a) Research and Demonstration Waiver
Budget Neutrality Report – Waiver Year 1998
Project number: 11-W-00048/6-03

I. Overview

This annual Budget Neutrality Report covers the period of January 1,1998 through December 31, 1998, Waiver Year 1998 (WY-98). It contains information necessary to demonstrate budget neutrality under the Oklahoma ***SoonerCure (SC)*** Demonstration Project. In addition to demonstrating budget neutrality, this report will also describe the methods used to arrive at the final Per Member Per Month (PMPM) expenditure amount, as set forth in the *Special Terms and Conditions* approved by the Health Care Financing Administration (HCFA). Comparative analyses were also performed relative to eligibles enrolled in the ***SC*** program and expenditure information for WY-97 and WY-98.

Updates/Amendments to Previous Year Budget Neutrality Report

At HCFA's request the State recalculated the Upper Payment Limits (otherwise known as the Fee-For-Service Equivalent) for WY-96 through WY-2000. This adjustment was made to the average PMPM for each year and reflects weighted values derived from base year[1] expenditures. The information contained in this report for WY-96 through WY-98 reflects the adjustments made to the Upper Payment Limits. Additionally, Attachment A contains Upper Payment Limit PMPM Cost information updates.

Savings Under the Waiver - 1996 Through I998

During WY-98 Oklahoma realized a savings of 12.15% resulting in a 3.18% increase from WY-96. Combined savings for WY-96 through WY-98 total 9.09%, resulting in overall savings of $85,203,996. Of this amount $59,642,797 accrues to the Federal government and $25,561,199 to the State. Additionally, PMPM costs for WY-98 decreased by $1.12 from the previous year.

1997-1998 Expenditure Comparison:

Overall expenditures increased by $30,006,158 (***SC Plus***[2] total expenditures increased by $14,080,118 while ***SC Choice*** total expenditures increased by $15,926,040) from the previous year. The most significant increases are in the ***SC Plus*** capitation payments followed by an increase in FFS expenditures in the ***SC Choice*** program.

FFS expenditures show a increase of $7,875,605 (***SC Plus*** FFS expenditures decreased by $3,680,758 while ***SC Choice*** FFS expenditures increased by $11,556,363). The increase in the ***SC Choice*** FFS expenditures appears to be consistent with a substantial increase in enrollment.

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1 See WY-96 Budget Neutrality Report, submitted to HCFA April 28, 1997, for detailed information regarding "Base Year" calculations/expenditures.

2 ***SoonerCare Plus*** is defined as the greater Oklahoma City, Tulsa, and Comanche metropolitan areas and surrounding counties. ***SoonerCare Choice*** is defined as the remainder of the State. The ***SoonerCare Plus*** areas of Oklahoma is served by health plans while the Primary Care Case Manager (PCCM) program serves the ***SoonerCare Choice*** areas.

Capitation expenditures show an overall increase of $20,360,962 (***SC Plus*** capitation expenditures increased by $15,711,224, while ***SC Choice*** capitation expenditures increased by $4,643,738). ***SC Plus*** capitation expenditures increase consists of a $4,029,978 increase in PMPM capitation payments and a $11,681,246 increase due to: year three supplement-! payments, newbor settlement payments, delivery payments, resident delivery payments, and resident primary care physician payments. Adjustments to expenditures show an overall increase of $1,769,590 (***SC Plus*** adjustments increased by $2,049,651 while ***SC Choice*** adjustments decreased by $280,061).

1997-1998 Eligible Enrollment Comparison:

The Aid to Families with Dependent Children (AFDC) and related Medicaid eligible recipient population increased by approximately 6% (16,850)[3] in WY-98 versus WY-97. Of the enrolled eligibles, the number of eligibles enrolled in managed care versus FFS increased by 4% (21,682). The most significant shift from FFS to managed care is realized in the ***SC Choice*** program where there was a 23% (21,339) increase from WY-97.

Budget Estimates Overview:

For the purpose of calculating the overall expenditure limit for the Demonstration Project, separate budget estimates have been calculated for each year (calendar year) of the waiver (see Attachment A). The annual estimates were then added together to obtain an expenditure estimate for the entire five year waiver period. The methodology used to perform these calculations was included in the State's first Budget Neutrality Report, submitted to HCFA on April 28, 1997.

Each yearly budget estimate is the sum of separate cost projections for each of the four Medicaid Enrollment Groups (MEG) eligible for participation in the ***SC*** program. The four enrollee groups are: (1) AFDC-Related recipients in ***SC Plus*** areas; (2) AFDC-Related recipients in ***SC Choice*** areas; (3) Aged, Blind, and Disabled (ABD) Medicaid recipients (regardless of **SSI** eligibility) in the ***SC Plus*** areas; and (4) ABD Medicaid recipients (regardless of **SSI** eligibility) in the ***SC Choice*** areas. *Note that groups **3** and **4** are not currently enrolled in SC. They are included in this report for informational purposes only and are not subject to a budget neutrality test at this time.*

Exclusions:

Excluded from the yearly budget estimates and the WY-98 calculations in the AFDC-Related MEG's are: the "spend down" portion of Oklahoma's medically-needy population; certified medically presumptive eligible - pregnancy related population; children in State custody; subsidized adoption children; illegal aliens; and individuals who have a Health Maintenance Organization for primary insurance coverage outside of ***SC***.

Data Sources:

The number of eligible months for each of the Medicaid-eligible populations has been drawn from the Department of Human Services mainframe PS/2 eligibility database for WY-98, January

3 Medicaid and ***SoonerCare*** eligible recipient population counts represent an estimated unduplicated count based on an average length of stay in the program for one year of 8 months for WY-96, 8.74 months for WY-97, and 8.44 months for WY-98.

1, 1998 through December 31, 1998. Expenditure information has been drawn from the Medicaid Management Information System's paid claims history for the same periods as above.

II. Actual PMPM Cost for Waives Year 1998

Actual PMPM cost for WY-98, as set forth in the *Special Terms and Conditions,* covers the period of January 1, 1998 - December 31, 1998. The ABD popu'ation was not enrolled during WY-98 and, accordingly, is excluded from this portion of the report.

WY-98 expenditures and eligible months for AFDC-Related MEGs are calculated to produce a PMPM cost and are subject to the exclusions listed in *Section* I- *Overview, Exclusions.* The sections below describe the methods used to determine WY-98 eligible months, actual expenditures, and PMPM cost.

Eligible Months:

The total eligible months count for WY-98 was determined by summing the monthly counts for the period January - December 1998 (Attachment B). Exhibit I below shows the total eligible months for each AFDC-Related MEG.

Aid Category SoonerCare Plus/SoonerCare Choice	Eligible Months
AFDC-Related - Oklahoma City Area	724,570
AFDC-Related - Tulsa Area	418,892
AFDC-Related - Comanche County Area	156,213
Total SC Plus	1,299,675
AFDC-Related - **SC Choice**	1,250,830
TOTAL AFDC-Related SC *Plus/Choice*	2,550,505

Actual Exwenditures & PMPM Costs:

Total expenditures for WY-98 were calculated in a five-step process, consisting of the following:

1. Paid Claims Analysis
2. Capitation Analysis
3. Graduate Medical Education Payment Adjustments
4. Federally Qualified Health Center (FQHC) Payment Adjustment
5. Prescription Rebate Adjustment

Each step is described separately below.

1. Paid Claims Analysis. The State first produced a paid claims report, documenting FFS expenditures for AFDC-Related MEG eligibles during the period January 1, 1998 - December 31, 1998. Pursuant to HCFA instructions, the report was sorted by date-of adjudication and as a

result, does not include dollars for some services rendered in WY-98, for which payment had not been made before December 31, 1998. Attachment C shows the total paid claims amounts by category of service.

2. Capitation Analysis. The State next produced a report documenting total capitation payments for WY-98, consisting of payments to MCOs in ***SC Plus*** areas and to Primary Care Physicians/Case Managers (PCP/CM) providers in ***SC Choice*** areas. Also included in the MCO capitation payments are the following: year three supplemental payments, newborn settlement payments, delivery payments, resident delivery payments, and resident primary care physician payments. The combined values of these capitation payments are shown as a single italicized line, the second item at the top of Attachment C, page 1.

3. *Graduate Medical Education (GME) Payment Adjustments.* Under the *Special Terms and Conditions* of Oklahoma's 1115(a) waiver, the State is permitted to make supplemental payments to the medical school? in Oklahoma City and Tulsa, as partial compensation to recognize the higher cost of care due to the appropriate inefficiencies of multiple missions. Specifically, each medical school submits quarterly to the State a listing of managed care enrollees who are using one of its physicians as a primary care provider (and their associated member months). Once the State has verified these lists against its own records, it makes a payment to the medical school.

The State made four payments to the medical schools in WY-98: one for the quarter ending March 31, a second for the quarter ending June 30, a third for quarter ending September 30 and a fourth for the quarter ending December 31. The combined value of these payments is $4,072,329. This figure is shown as an upward adjustment to total expenditures at the bottom of Attachment C, page 3. Payments were made to the Oklahoma University Health Sciences Center (Oklahoma City), Oklahoma University Health Sciences Center (Tulsa), and the Oklahoma State University College of Osteopathy (Tulsa).

4. FQHC Payment Adjustment. Under the *Special Terms and Conditions* of Oklahoma's 1115(a) waiver, the State also is permitted to make supplemental payments to Federally Qualified Health Centers (FQHCs) that participate in managed care. This supplemental payment is made in lieu of offering reasonable cost reimbursement to the FQHCs.

In SC ***Plus*** areas, the State has committed to paying FQHCs for each MCO enrollee who uses one of their centers for primary care. The combined value of payments made during WY-98 is $76,670 (Konawa $704, Community Health Centers $24,976, Morton Comprehensive Health Services $40,447, and Southeast Area Health Center $10,543). This figure is shown as an upward adjustment to total expenditures at the bottom of Attachment C, page 3.

In addition to making supplemental payments to FQHCs serving MCO enrollees, the State also pays an enhanced capitation rate to one of the FQHCs serving clients in the ***SC Choice*** program (the enhancement equals $1.00 PMPM). The dollars associated with the ***SC Choice*** enhanced payment are not separately reported here, but are instead included in the capitation line item at the top of Attachment C, page 1.

5. *Prescription Rebate Adjustment.* MCO capitation rates are established net of prescription rebate dollars, thereby making it unnecessary to adjust expendirures for the AFDC-Related ***SC Plus*** population to account for rebates. However, the State still pays pharmacy claims for the ***SC Choice*** AFDC-Related population on a FFS basis. To account for estimated rebate dollars

(which are not tracked separately for AFDC-Related ***SC Choice*** clients), the State has reduced total expenditures for the ***SC Choice*** population by one percent, $1,520,807, (see WY-96 *Budget Neutrality Report*, Section II for an explanation of the one percen: factor). This figure is shown as a downward adjustment at the bottom of Attachment C, page 3.

The final, adjusted expenditure amount for WY-98 is divided by total eligible months to arrive at the actual PMPM for the AFDC-Related MEGs. As shown on Attachment A, the resultant value is $121.98.

III. Savings under the Waiver - 1996 through 1998

As stated above the actual PMPM for the AFDC-Related MEGs for WY-98 is $121.98, the upper limit for this same period and group is $138.85, thereby, demonstrating budget neutrality. Total and PMPM actual expenditures calculated for WY-96, WY-97, WY-98 and the three waiver years combined are presented in Attachment D and include trended FFS equivalent values for the same period. During WY-97 Oklahoma realized a savings of 5.54%. This increased during WY-98 by 6.61% leaving total savings for WY-98 at 12.15%. Combined savings for WY-96 through WY-98 total 9.09%. This has resulted in overall savings of $85,203,996 of which $59,642,797 accrues to the Federal government and $25,561,199 to the State. **A** brief overview of WYs-96, 97, 98 and the three years combined is provided below.4

Waiver Year 1996 Actual Expenditures versus Fee-For-Sewice Equivalent:

As shown in Exhibit II below, Oklahoma's waiver program PMPM costs for WY-96 were 91% of the FFS equivalent PMPM cost, thereby demonstrating savings versus FFS. The total savings amount to $25,670,807 (8.97%), of which $17,969,565 accrues to the Federal government and $7,70 1,242 to the State.

Exhibit II
Waiver Year 1996 Savings

Comparison Groups	Expenditures	Eligible Months	PMPM cost
WY 1996 Fee-For-Service Equivalent	$286,109,863	2,337,528	$122.40
WY 1996 Actual Expenditures	$260,439,055	2,337,528	$111.42
Total Savings WY 1996	($25,670,807)	-----	($10.98)
Federal Share	($17,969,565)	-----	($7.69)
State Share	($7,701,242)	-----	($3.29)
Waiver Year I - Jan. through Dec. 1996 Savings =		***8.97%***	

4 The overview information provided for WY-96, 97, and **98** have been adjusted to reflect corrections made to the upper payment limit at **HCFA's** request.

Waiver Year 1997 Actual Expenditures versus Fee-For-Service Equivalent:

As shown in Exhibit III below, Oklahoma's waiver program PMPM costs for WY-97 were 94.5% of the FFS equivalent PMPM cost, thereby demonstrating savings versus FFS. The total savings amount to $16,493,228 (5.54%), of which $11,545,259 accrues to the Federal government and $4,947,968 to the State.[5]

Exhibit III
Waiver Year 1997 Savings

Comparison Groups	Expenditures	Eligible Months	PMPM cost
WY 1997 Fee-For-Service Equivalent	$297,593,610	2,282,744	$130.37
WY 1997 Actual Expenditures	$281,100,382	2,282,744	$123.14
Total Savings WY 1997	($16,493,228)	-----	($7.23)
Federal Share	($11,545,259)	-----	($5.06)
State Share	($4,947,968)	-----	($2.17)
Waiver Year II - Jan. through Dec. 1997 Savings =		**5.54%**	

Waiver Year 1998 Actual Expenditures versus Fee-For-Service Equivalent:

As shown in Exhibit IV below, Oklahoma's waiver program PMPM costs for WY-98 were 87.85% of the FFS equivalent PMPM cost; thereby demonstrating savings versus FFS. The total savings amount to $43,039,961 (12.15%), of which $30,127,973 accrues to the Federal government and $12,911,988 to the State.

Exhibit IV
Savings Waiver Year 1998

Comparison Groups	Expenditures	Eligible Months	PMPM Cost
WY 1998 Fee-For-Service Equivalent	$354,146,501	2,550,505	$138.85
WY 1998 Actual Expenditures	$311,106,540	2,550,505	$121.98
Total Saving WY 1998	($43,039,961)	-----	($16.88)
Federal Share	($30,127,973)	-----	($11.81)
State Share	($12,911,988)	-----	($5.06)
Waiver Year III - Jan. through Dec. 1998 Savings =		**12.15%**	

5 Refer to WY-97 Budget Neutrality Report (submitted to HCFA September 11, 1998) for more detailed information.

Combined Savings Waiver Year 1996-1998 Actual Expenditures versus Fee-For-Service Equivalent:

As shown in Exhibit V below, Oklahoma's waiver program PMPM costs for WY-96 through WY-98 combined were 90.9% of the FFS equivalent PMPM cost, thereby demonstrating significant savings during the first three years of the program versus FFS. Total savings amount to $85,203,996 (9.09%), of which $59,642,797 accrues to the Federal government and $25,561,199 to the State.

Exhibit V
Combined Savings Waiver Year 1996-1998

Comparison Groups	Expenditures	Eligible Months	PMPM cost
WY 1996-1998 Fee-For-Sarvice Equiv.	$937,849,974	7,170,777	$130.79
WY 1996-1998 Actual Expenditures	$852,645,977	7,170,777	$118.91
Total Savings WY 1996-1998	($85,203,996)	-----	($11.88)
Federal Share	($59,642,797)	-----	($8.32)
State Share	($25,561,199)	-----	($3.56)
Waiver Year *I, II & III* - Jan. *1996* through *Dec. 1998* Savings =		**9.09%**	

IV. Significant Changes From Waiver Year 1997 to Waiver Year 1998

1997-1998 Eligible (Member Months) Enrollment Comparison:

(Medicaid and Soonercare eligible recipient population counts represent an estimated unduplicated count based on an average length of stay in the program for one year of: 8 monthsfor WY-96, 8.74 monthsfor WY-97. and 8.44 monthsfor WY-98.)

The AFDC and related Medicaid eligible count (see Attachment E) shows a 6% increase in the eligible population, consequently, the number of eligibles enrolled in managed care versus FFS has increased by 12% (approximately 21,682 eligibles). The significant increase in the Medicaid program is largely due to the enactment of Senate Bill 639 and Title XXI.[6]

[6] Title XXI funds were used to expand Medicaid coverage. This option, for Oklahoma, is available for children who do not qualify for Medicaid under State rules in effect as of April 15, 1997. Under this option current Medicaid rules would apply. The application was approved by the HCFA on May 5, 1998 with an effective date of December 1, 1997. Senate Bill 639 was enacted during the State's 1997 Legislative Session. This law expanded Medicaid eligibility through the State's ***Soonercare*** program. It required the Oklahoma Health Care Authority (OHCA) to expand Medicaid eligibility for pregnant females and for children born on or after October 1, 1983. This includes those persons with annual incomes up to one-hundred-eighty-five (185%) percent of the Federal Poverty Level (FPL) which represents $25,253 per year for a family of three. This expansion became effective December 1, 1997.

The most significant shift from FFS to managed care is realized in the ***SC Choice*** areas where there was a 30% (approximately 21,357eligibles) increase from the previous year. The ***SC Plus*** areas realized a 3% (approximately 3,798 recipients) increase in enrollment in the Medicaid program, however, there was a, less than 1%, decrease in the percent of FFS recipients enrolled in the ***SoonerCare Plus*** program. (see Attachment E for a complete overview).

1997-1998 ***Expenditures Comparison:***

As shown in Attachment E, the ***SoonerCare*** program expenditures show an overall increase of $30,006,158 and represent an 11% increase in total program expenditures. This increase consists of capitation payments which represent 68% ($20,360,962) of the increase, FFS payments which represent 27% ($7,875,605) of the increase, and adjustments which represent 5% ($1,769,590) of the increase in expenditures.

The ***SC Plus*** capitation expenditures increased by $15,711,224. This increase consists of a $4,029,978 increase in PMPM capitation payments and a $11,681,246 increase due to: year three supplemental payments, newborn settlement payments, delivery payments, resident delivery payments, and resident primary care physician payments. The ***SC Choice*** capitation expenditures increased by $4,649,738 and appears to be consistent with the increase in program participation. Additionally, ***SC Plus*** FFS expenditures decreased by $3,680,758 while ***SC Choice*** FFS expenditures increased by $11,556,363. Adjustments (supplemental payment, prescription drug rebates, etc.) show an overall increase of $1,769,590 (***SC Plus*** adjustments increased by $2,049,651 while ***SC Choice*** adjustments decreased by $280,061).

Savings: Per Member Per Month Cost Comparison
Waiver Year 1996 through 2000

Waiver Year/MEG	Upper Payment PMPM Cost	Actual PMPM Cost	Savings
WY-1996:			
AFDC & REL. - Urban	$121.60	$113.36	6.78%
AFDC & REL. - Rural	$123.34	$109.19	11.47%
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AFDC & REL. - Rural	$131.37	$124.52	5.21%
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Average PMPM Cost Per Group	**$130.37**	**$123.14**	**5.54%**
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ABD Non-Inst. - Rural	$0.00	$0.00	0.00%
Average PMPM Cost Per Group	**$138.85**	**$121.98**	**12.15%**
WY-1999:			
AFDC & REL. - Urban	$146.93		
AFDC & REL. - Rural	$149.03		
ABD Non-Inst. - Urban	$536.14		
ABD Non-Inst. - Rural	$427.26		
Average PMPM Cost Per Group	**$191.77**		
WY-2000:			
AFDC & REL. - Urban	$156.49		
AFDC & REL. - Rural	$158.73		
ABD Non-Inst. - Urban	$567.56		
ABD Non-Inst. - Rural	$452.30		
Average PMPM Cost Per Group	**$203.84**		
Avg. PMPM Cost Per MEG/Per 1996-1998	**$130.79**	**$118.91**	**9.09%**

Attachment B

Oklahoma Health Care Authority
Waiver Year 1998 Eligible Member Months

1998 Member Months For Medicaid Program (FFS & *SoonerCare*)

Service Area	Jan-98	Feb-98	Mar-98	Apr-98	May-98	Jun-98	Jul-98	Aug-98	Sep-98	Oct-98	Nov-98	Dec-98	Total
AFDC - OKC	58,445	59,159	59,713	59,962	59,854	60,086	60,178	61,160	61,436	61,732	61,721	61,124	**724,570**
AFDC - Tulsa	34,312	34,746	35,089	34,868	35,089	35,210	34,969	35,113	34,983	34,982	35,029	34,502	**418,892**
AFDC - Comanche	12,241	12,391	12,660	12,702	12,717	12,925	13,052	13,423	13,468	13,584	13,527	13,523	**156,213**
AFDC Rural	97,848	99,754	102,092	103,018	103,712	103,588	103,273	105,600	106,847	107,866	108,655	108,577	**1,250,830**
Total	**202,846**	**206,050**	**209,554**	**210,550**	**211,372**	**211,809**	**211,472**	**215,296**	**216,734**	**218,164**	**218,932**	**217,726**	**2,550,505**

Total Urban	**1,299,675**
Total Rural	**1,250,830**
Total	**2,550,505**

1998 Member Months Enrolled in *SoonerCare* Program

Service Area	Jan-98	Feb-98	Mar-98	Apr-98	May-98	Jun-98	Jul-98	Aug-98	Sep-98	Oct-98	Nov-98	Dec-98	Total
AFDC - OKC	42,554	44,000	45,166	45,748	46,451	46,209	45,250	44,696	44,657	45,463	47,036	46,683	**543,913**
AFDC - Tulsa	24,268	25,055	26,009	26,280	26,943	26,830	26,037	25,633	25,761	25,896	26,059	25,933	**310,704**
AFDC - Comanche	9,024	9,313	9,563	9,948	10,007	9,934	8,211	9,665	9,699	9,974	10,491	10,395	**116,224**
AFDC - Rural	49,654	52,246	63,562	58,573	72,608	71,297	68,603	68,215	68,387	69,038	72,716	74,627	**789,526**
Total	**125,500**	**130,614**	**144,300**	**140,549**	**156,009**	**154,270**	**148,101**	**148,209**	**148,504**	**150,371**	**156,302**	**157,638**	**1,760,367**

Total Urban	**970,841**
Total Rural	**789,526**
Total	**1,760,367**

Oklahoma Health Care Authority
Expenditures - Waiver Year 1998

SERVICE TYPE	SC PLUS OKLAHOMA	SC PLUS TULSA	SC PLUS COMANCHE	SC PLUS TOTAL SC PLUS	SC CHOICE RURAL	TOTAL EXPENDITURES
BIRTHING CENTER	$13,454	$0	$0	**$13,454**	$11,213	**$24,667**
CAPITATION PAYMENTS	*$66,536,347*	*$38,513,249*	*$12,036,879*	***$117,086,475***	*$10,622,564*	***$127,709,039***
CASE MANAGEMENT	$354,524	$165,399	$73,201	**$593,124**	$930,244	**$1,523,368**
COMM MEN HLTH CLIN	$737,356	$343,215	$44,668	**$1,125,239**	$9,466,217	**$10,591,456**
DENTAL	$162,287	$70,706	$32,904	**$265,897**	$4,457,377	**$4,723,274**
DRUGS	$789,764	$1,037,036	$237,704	**$2,064,504**	$12,827,709	**$14,892,213**
EARLY INTERVENTION	$109,856	$83,054	$19,505	**$212,415**	$133,653	**$346,068**
EYE EXAM & GLASSES	$93,442	$47,782	$28,702	**$169,926**	$1,784,721	**$1,954,647**
FAM PLAN CLINIC/PHY	$99,376	$38,539	$13,270	**$151,185**	$626,300	**$777,485**
FAM PLAN HSP IP	$0	$0	$1,167	**$1,167**	$9,208	**$10,375**
FAM PLAN HSP OP	$28,719	$5,685	$6,925	**$41,329**	$98,201	**$139,530**
FAM PLAN PHARMACY	$12,654	$10,116	$4,688	**$27,458**	$318,358	**$345,816**
FED QUAL HLTH CTRS	$120,923	$24,513	$0	**$145,436**	$56,216	**$201,652**
FS AMBUL SUR CTR	$21,126	$9,187	$1,654	**$31,967**	$161,110	**$193,077**
FS KIDNEY DIALYSIS	$24,001	$0	$0	**$24,001**	$0	**$24,001**
HOME HEALTH	$20,242	$17,008	$4,872	**$42,122**	$284,107	**$326,229**
HSP EMERGENCY ROOM	$69,091	$22,648	$13,267	**$105,006**	$1,012,732	**$1,117,738**
IP ACUTE PSY/DETOX	$676,502	$173,393	$66,612	**$916,507**	$1,422,439	**$2,338,946**
IP HSP CROSSOVER	$764	$0	$0	**$764**	$3,052	**$3,816**
IP HSP FS PSYCH	$886,446	$1,185,778	$212,312	**$2,284,536**	$8,230,138	**$10,514,674**
IP HSP MATERNITY	$3,677,302	$2,254,653	$481,273	**$6,413,228**	$23,232,759	**$29,645,987**
IP HSP REGULAR	$5,715,465	$5,507,840	$992,265	**$12,215,570**	$33,344,625	**$45,560,195**
LAB/X-RAY	$72,948	$52,179	$10,172	**$135,299**	$369,138	**$504,437**
LTC - ICF	$65,724	$0	$0	**$65,724**	$117,931	**$183,655**
LTC - ICFMR	$29,007	$0	$0	**$29,007**	$183,132	**$212,139**
LTC - SNF	$83,075	$0	$0	**$83,075**	$0	**$83,075**
MEDICAL SUPPLIES	$40,829	$24,205	$19,875	**$84,909**	$557,606	**$642,515**
NTMC	$0	$0	$0	**$0**	-$319	**-$319**

Attachment C, pg. 2

SERVICE TYPE	SC PLUS				SC CHOICE	TOTAL
	OKLAHOMA	TULSA	COMANCHE	TOTAL SC PLUS	RURAL	EXPENDITURES
NURSE MIDWIFE	$17,107	$4,046	$0	$21,153	$303,403	$324,556
NURSE PRACTIONER	$1,445	$8,017	$4,639	$14,101	$10,084	$24,185
OHD - CLINIC	$155,289	$126,090	$11,038	$292,417	$879,066	$1,171,483
OP ACUTE PSY/CHM DP	$230,070	$45,235	$67,836	$343,141	$940,432	$1,283,573
OP HSP CROSSOVER	$11	-$124	$18	-$95	$1,772	$1,677
OP HSP DIAG XRAY	$128,128	$36,478	$21,524	$186,130	$726,213	$912,343
OP HSP FS PSYCH	$108,571	$262,658	$3,626	$374,855	$715,422	$1,090,277
OP HSP LAB	$359,516	$124,463	$91,879	$575,858	$2,201,575	$2,777,433
OP HSP MATERNITY	$457,031	$205,668	$89,941	$752,640	$1,806,836	$2,559,476
OP HSP REGULAR	$974,560	$431,409	$455,869	$1,861,838	$5,808,282	$7,670,120
OP HSP THER XRAY	$12,178	$10,837	$0	$23,015	$27,970	$50,985
OTHER CROSSOVER	$833	$0	$31	$864	$876	$1,740
OTHER PRACTIONER	$58,929	$12,420	$23,478	$94,827	$803,085	$897,912
PCP DIAG XRAY	$6,432	$4,780	$1,157	$12,369	$64,827	$77,196
PCP LAB	$21,556	$17,364	$4,525	$43,445	$307,395	$350,840
PCP MATERNITY	$358,127	$245,452	$70,809	$674,388	$4,567,450	$5,241,838
PCP NOT OV-OTH	$817,954	$492,443	$98,846	$1,409,243	$4,538,144	$5,947,387
PCP OV-OTHER	$252,631	$134,912	$50,533	$438,076	$1,240,444	$1,678,520
PSYC/CXSM DEP	$15,772	$11,925	$3,394	$31,091	$99,665	$130,756
PCP THER XRAY	$4,735	$33	$0	$4,768	$1,227	$5,995
PSYCH/CXSM DEP	$3,283	$611	$10	$3,904	$21,175	$25,079
PHYS REG DIAG XRAY	$62,962	$47,568	$11,150	$121,680	$540,329	$662,009
PHYS REG LAB	$33,572	$25,186	$5,403	$64,161	$299,039	$363,200
PHYS REG MATERNITY	$901,119	$276,721	$87,588	$1,265,428	$5,777,414	$7,042,842
PHYS REG NOT OV-OTH	$692,025	$480,955	$111,710	$1,284,690	$4,517,858	$5,802,548
PHYS REG OV-OTHER	$48,578	$24,591	$8,194	$81,363	$414,761	$496,124
PHYS REG THER XRAY	$11,613	$11,095	$738	$23,446	$74,443	$97,889
PHYSICIAN PSYCH	$45,896	$48,644	$8,941	$103,481	$367,358	$470,839
PSYCHOLOGIST	$21,039	$7,672	$187	$28,898	$172,253	$201,151
RESIDENTL BEHAV MGT	$393,921	$359,881	$70,791	$824,593	$1,757,729	$2,582,322
ROOM & BOARD	$5,610	$228	$3,106	$8,944	$38,784	$47,728
RTC	$500,049	$1,180	$85,439	$586,668	$1,546,436	$2,133,104
SCHOOL-BASED EPSDT	$225,703	$133,061	$80	$358,844	$382,648	$741,492
SPEC HOME NUR SERV	$0	$16,056	$0	$16,056	$42,103	$58,159

Attachment C, pg. 3

SERVICE TYPE	SC PLUS OKLAHOMA	SC PLUS TULSA	SC PLUS COMANCHE	SC PLUS TOTAL SC PLUS	SC CHOICE RURAL	TOTAL EXPENDITURES
SPEECH & HEARING	$380	$242	$43	**$665**	$10,740	**$11,405**
TRANSPORTATION	$65,312	$50,685	$ 24,339	**$140,336**	$785,091	**$925,427**
XOVER - OTHER PRAC	$556	$0	$0	**$556**	$0	**$556**
Z99A	$990	$180	$3	**$1,173**	$14,103	**$15,276**
TOTAL	**$87,434,151**	**$53,244,763**	**$15,718,780**	**$156,397,694**	**$152,080,653**	**$308,478,347**

	Urban	Rural	Total
Total Expenditures	**$156,397,694**	**$152,080,653**	**$308,478,347**
Adjustments:			
OU Teaching Hospitals	*$4,072,329*	*$0*	***$4,072,329***
Federally Qualified H.C.	*$76,670*	*$0*	***$76,670***
1% Prescription Drug Rebate	*$0*	*($1,520,807)*	***($1,520,807)***
Total Adjustments	***$4,148,999***	***($1,520,807)***	***$2,628,193***
Total Adjusted Expenditures	**$160,546,693**	**$150,559,847**	**$311,106,540**

Attachment D

Oklahoma Health Care Authority
Savings - Waiver year 1996 Through 1998

Waiver Year I - 1996 Savings = 8.97% *(01/01/96 through 12/31/96)*

Comparison Groups	Expenditures	Eligible Months	PMPM cost
WY 1996 Fee-For-Service Equivalent	$286,109,863	2,337,528	$122.40
WY 1996 Actual Expenditures	$260,439,055	2,337,528	$111.42
Total Saving WY 1996	($25,670,807)	-----	($10.98)
Federal Share	($17,969,565)	-----	($7.69)
State Share	($7,701,242)	-----	($3.29)

Waiver Year II - 1997 Savings = 5.54% *(01/01/97 through 12/31/97)*

Comparison Groups	Expenditures	Eligible Months	PMPM cost
WY 1997 Fee-For-Service Equivalent	$297,593,610	2,282,744	$130.37
WY 1997 Actual Expenditures	$281,100,382	2,282,744	$123.14
Total Saving WY 1997	($16,493,228)	-----	($7.23)
Federal Share	($11,545,259)	-----	($5.06)
State Share	($4,947,968)	-----	($2.17)

Waiver Year III - 1998 Savings = 12.15% *(01/01/98 through 12/31/98)*

Comparison Groups	Expenditures	Eligible Months	PMPM cost
WY 1998 Fee-For-Service Equivalent	$354,146,501	2,550,505	$138.85
WY 1998 Actual Expenditures	$311,106,540	2,550,505	$121.98
Total Saving WY 1998	($43,039,961)	-----	($16.88)
Federal Share	($30,127,973)	-----	($11.81)
State Share	($12,911,988)	-----	($5.06)

Waiver Year I-III, 1996-1998 Savings = 9.09% *(01/01/96 through 12/31/98)*

Comparison Groups	Expenditures	Eligible Months	PMPM cost
WY 1996-1998 Fee-For-Service Equiv.	$937,849,974	7,170,777	$130.79
WY 1996-1998 Actual Expenditures	$852,645,977	7,170,777	$118.91
Total Saving WY 1996-1998	($85,203,996)	-----	($11.88)
Federal Share	($59,642,797)	-----	($8.32)
State Share	($25,561,199)	-----	($3.56)

Attachment E

Oklahoma Health Care Authority
1996-1998 Eligible Member Months Enrollment and Expenditures Comparisons

Eligibles Member Months Comparison:

Total Unduplicated Est. Medicaid Eligibles

	SC Plus	SC Choice	Total	Change From Previous Year
Waiver Year 1996	156,074	136,118	**292,191**	**0**
Waiver Year 1997	150,192	135,151	**285,343**	**(6,848)**
Waiver Year 1998	153,990	148,203	**302,193**	**16,850**

Unduplicated Est. Medicaid Eligibles Enrolled in *SC*

	SC Plus	SC Choice	Total	Change From Previous Year
Waiver Year 1996	102,620	20,599	**123,219**	**0**
Waiver Year 1997	114,686	72,207	**186,893**	**63,674**
Waiver Year 1998	115,029	93,546	**208,574**	**21,682**

Percent of Medicaid Eligibles Enrolled in *SC*

	SC Plus	SC Choice	Total	Change From Previous Year
Waiver Year 1996	0.66	0.15	**0.42**	**0.00**
Waiver Year 1997	0.76	0.53	**0.65**	**0.23**
Waiver Year 1998	0.75	0.63	**0.69**	**0.04**

Average Length of Stay:
1996 – 8 months
1997 – 8.74 months
1998 – 8.44 months (decrease due to long-term eligibles disenrolling)

Expenditures Comparison:

Fee-For-Service Expenditures

	SC Plus	SC Choice	Total	Change From Previous Year
Waiver Year 1996	$56,236,503	$117,647,490	**$173,883,993**	**$0**
Waiver Year 1997	$42,991,977	$129,901,726	**$172,893,703**	**($990,290)**
Waiver Year 1998	$39,311,219	$141,458,089	**$180,769,308**	**$7,875,605**

Capitation Expenditures

	SC Plus	SC Choice	Total	Change From Previous Year
Waiver Year 1996	$84,604,383	$2,458,684	**$87,063,067**	**$0**
Waiver Year 1997	$101,375,251	$5,972,826	**$107,348,077**	**$20,285,010**
Waiver Year 1998	$117,086,475	$10,622,564	**$127,709,039**	**$20,360,962**

Adjustments

	SC Plus	SC Choice	Total	Change From Previous Year
Waiver Year 1996	$693,058	($1,201,062)	($508,004)	**$0**
Waiver Year 1997	$2,099,348	($1,240,746)	$858,602	**$1,366,607**
Waiver Year 1998	$4,148,999	($1,520,807)	$2,628,193	**$1,769,590**

Total Expenditures

	SC Plus	SC Choice	Total	Change From Previous Year
Waiver Year 1996	$141,533,944	$118,905,112	**$260,439,055**	**$0**
Waiver Year 1997	$146,466,576	$134,633,806	**$281,100,382**	**$20,661,327**
Waiver Year 1998	$160,546,693	$150,559,847	**$311,106,540**	**$30,006,158**